**UNPUBLISHED**

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE NORTHERN DISTRICT OF IOWA**
**CENTRAL DIVISION**

GARY F. WEISHAAR,

Plaintiff,

vs.

JO ANNE B. BARNHART,
Commissioner of Social Security,[1]

Defendant.

No. **C01-3048-MWB**

**REPORT AND RECOMMENDATION**

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[1] On November 14, 2001, Jo Anne B. Barnhart was sworn in as Commissioner of Social Security, and she is hereby substituted as defendant in this action. *See* Fed. R. Civ. P. 25(d)(1); *cf.* Fed. R. App. P. 43(c)(2).

## *I. INTRODUCTION*

The plaintiff Gary F. Weishaar ("Weishaar") appeals the denial by the administrative law judge ("ALJ") of Title II disability insurance ("DI") benefits. Weishaar argues the ALJ erred in the following respects: (1) the ALJ improperly relied on the medical-vocational guidelines, and (2) the ALJ failed to ask a proper hypothetical question of the Vocational Expert. (Doc. No. 6, pp. 8-11)

## *II. PROCEDURAL AND FACTUAL BACKGROUND*

### *A. Procedural Background*

Weishaar filed an application for DI benefits on January 25, 1999, alleging a disability onset date of November 30, 1997. (R. 103-05) The application was denied initially (R. 82-83, 86-89), and upon reconsideration (R. 84-85, 92-95). Weishaar then requested a hearing, which was held on May 23, 2000, in Mason City, Iowa, before ALJ Thomas M. Donahue. (R. at 53-81) Attorney Kelley Rice represented Weishaar at the hearing. Weishaar and Vocational Expert ("VE") Jeff Johnson testified at the hearing.

On August 5, 2000, the ALJ ruled Weishaar was not entitled to DI benefits. (R. 9-32) The Appeals Council of the Social Security Administration denied Weishaar's request for review on February 23, 2001 (R. 6-7), making the ALJ's decision the final decision of the Commissioner.

Weishaar filed a timely complaint on April 27, 2001, seeking judicial review of the ALJ's ruling. (Doc. No. 1) Pursuant to Administrative Order #1447, entered September 20, 1999, Chief Judge Mark W. Bennett referred this matter to the undersigned United States Magistrate Judge pursuant to 28 U.S.C. § 636(b)(1)(B), for the filing of a report and recommended disposition of Weishaar's claim. Weishaar filed a brief supporting his claim on August 24, 2001 (Doc. No. 6). On October 1, 2001, the Commissioner of Social

Security filed a responsive brief (Doc. No. 8). The court now deems the matter fully submitted, and pursuant to 42 U.S.C. § 405(g), turns to a review of Weishaar's claim for benefits.

### *B. Factual Background*

#### *1. Introductory facts and Weishaar's daily activities*

At the time of the ALJ hearing on May 23, 2000, Weishaar was forty-nine years old, between six foot one inch and six foot two inches tall, and weighed 225 pounds. (R. 55-56) He had last worked from August to December 1999, at a seasonal, part-time job pumping manure wagons.[2] (R. 59) Before that, he had worked for 27 years at Longview Waste System, until he quit in November 1997, because of a shoulder injury.[3] (R. 60-62)

Weishaar testified he graduated from high school after three years of special education. (R. 56) He was in the Air Force for four months, but was discharged because he "was unable to adapt to military service." (R. 57)

Weishaar described his disability as follows:

> I worked as a garbage man driving a truck for 30 years and then I had the accident and I, you know I went to all kinds of doctors and stuff and just wasn't able to do certain things again and just and things have gotten really tough. . . . [On approximately February 14, 1997,] I was carrying a TV . . . and it was real icy in the back and I slipped and I fell and, and I don't remember a whole lot after that.

(R. 58) As a result of the fall, Weishaar suffered a severe right shoulder rotator cuff injury. (*Id.*) Also, he hit his head in the fall, and since then has suffered from depression and severe headaches. (*Id.*)

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[2]According to Weishaar, this job required no lifting, carrying, or driving, but primarily involved sitting and operating levers. (R. 60)

[3]His alleged disability onset date is November 30, 1997.

Weishaar testified that at least once a day, he suffers from pain shooting down from the site of his rotator cuff injury to his arm, hand, and fingers. (R. 63-64) In addition, he suffers from constant sharp pains in his hand and fingers, together with numbness and tingling. (R. 64) Sometimes the pain travels to his neck. (R. 65) Reaching for things aggravates the pain. The pain in his fingers affects his ability to pick things up without dropping them. The only medication Weishaar takes for his pain is ibuprofen, but he also uses ice packs and exercise. In the two years before the hearing, the pain had not gotten any better or worse. (R. 66-67)

Weishaar testified he was first diagnosed with depression about a year before the ALJ hearing. (R. 67) As a result of the depression, he gets "really angry," and takes his anger out on his family. (R. 68) At the time of the hearing, he was taking Salexa and Trazadone to treat the depression. (R. 67)

He described his headaches as follows: "They, like they'll get like in the back of my head and shoot into like my ears and just kind of pounding." (R. 71) He has these headaches about once a week. (*Id.*) He had a prescription for Ultram to treat the headaches, but at the time of the hearing, he was just taking Tylenol. (*Id.*)

Weishaar felt he could lift "around 30 pounds" with both hands, but not routinely. (R. 73) He stated he has trouble kneeling and squatting as a result of an old knee surgery. (R. 74) Weishaar testified he was active in sports before his shoulder injury, but is no longer able to participate in basketball, bowling, or softball. (*Id.*) He does not like to drive because turning the steering wheel bothers him, and because he suffers from "night blindness." (R. 75)

In a Supplemental Disability Report completed by Weishaar on January 28, 1999, Weishaar stated he visits others two or three days a week for a couple of hours a day. (R. 146) He is on the board of directors of a children's softball and baseball league, and is vice president of a youth junior bowling league. (*Id.*) He helps with the household chores by washing dishes and cleaning the house, and drives his car "around town" about two hours

a day. (R. 146-47) He goes to the store to get things for his wife, picks up prescriptions, and mails letters. (R. 147) He also goes for walks and watches television. (*Id.*)

In a questionnaire dated February 18, 2000, Weishaar indicated he could do yardwork, go shopping, attend church, stand and walk. He has a good appetite. He can dress himself, climb stairs, kneel, do daily home chores, drive a car, carry light things, handle things, ride in a car, visit with other people, crawl, bend over, see and hear satisfactorily, speak so can be understood, grip with his hands, squat, read a newspaper, read a letter, write his name, and write a letter. (R. 177)

### *2. Weishaar's medical history*

Weishaar's relevant medical records are summarized in Appendix A to this opinion. His relevant medical history begins on February 14, 1997, when he injured his right shoulder after a fall on the ice. (R. 222) When seen in the Kossuth Regional Health Center emergency room, he gave a history of a previous fracture to the midshaft right humerus, and a previous shoulder injury with a prolonged recovery. (*Id.*) The diagnosis by the emergency room physician, William Parker, M.D., was "right shoulder injury without signs of fracture or dislocation." (*Id.*) X-rays revealed degenerative changes at the right acromioclavicular joint and a chronic deformity of the midshaft of the right humerus. (R. 221)

On February 19, 1997, Weishaar was seen by Dr. Parker for a recheck of his shoulder injury. (R. 198) Dr. Parker diagnosed a shoulder strain and contusion, and referred Weishaar to physical therapy for evaluation and treatment. (*Id.*) Dr. Parker next saw Weishaar on February 21, 1997. (R. 197) Weishaar reported minimal improvement of his shoulder, and also complained of posterior headaches. Dr. Parker prescribed Darvocet, Flexeril, and Ibuprofen, and referred Weishaar to Raymond Emerson, M.D. (*Id.*)

Weishaar was seen by Dr. Emerson on March 17, 1997. (R. 217) Dr. Emerson observed signs and symptoms of a rotator cuff tear. (*Id.*) He prescribed Darvocet for pain. (R. 218)

On June 25, 1997, Weishaar was seen in the Kossuth Regional Health Center emergency room after being hit in the neck by a baseball bat while umpiring a game. (R. 219) After being struck by the bat, Weishaar lost consciousness for a minute or two, and then was dizzy and unsteady. (*Id.*) In the emergency room, he complained of pain in his posterior neck, but a physical examination and X-rays were normal (R. 219-20)

Dr. Emerson saw Weishaar again on September 12, 1997, and Weishaar advised Dr. Emerson he would like to have surgery to repair his rotator cuff. (R. 216) The surgery was performed on December 2, 1997.[4] (R. 230) In his preoperative history and physical, Weishaar said he was having problems with headaches and with sleeping because of pain and anxiety in connection with his shoulder problems. (R. 231) The operative procedures performed were arthroscopy, bursoscopy, anterior decompression and partial excision of distal clavicle, and open rotator cuff repair. (R. 232) The postoperative diagnosis of Weishaar's shoulder was "very large rotator cuff tear" and "impingement syndrome." (*Id.*) There were no complications with the surgery. (*Id.*)

By January 5, 1998, Weishaar was "gradually but slowly obtaining range of motion." (R. 209) On February 4, 1998, Dr. Emerson noted that Weishaar's range of motion was improved, although only slightly, and he was "still rather stiff." (*Id.*) Dr. Emerson restricted Weishaar to no overhead use of his right arm, and set a target date for return to full duty of three to four months from the date of the visit. (*Id.*)

Over the next few months, Weishaar demonstrated slow but steady improvement. (R. 207-08) On April 13, 1998, Weishaar reported discomfort and tingling in his right wrist and hand, which Dr. Emerson concluded were "of unknown etiology." (R. 207) Dr.

[4]November 30, 1997, is the alleged onset date of Weishaar's disability.

Emerson noted no evidence of hand weakness. (*Id.*) Weishaar apparently also complained about his neck, but cervical X-rays were essentially unremarkable. (*Id.*)

On May 18, 1998, six months after the surgery, Weishaar had a follow-up visit with Dr. Emerson, who noted Weishaar was "making slow, but steady improvement in range of motion and decreased shoulder pain," but expressed concern with Weishaar's continued complaints of wrist pain. (R. 203) Dr. Emerson's impression was "possible mild carpal tunnel syndrome." (*Id.*) His notes reflect the following plan:

> I think he is making steady improvement, although it is slow. I do not think he will be able to handle his previous type of work yet without some restrictions. Hopefully with continued strengthening program, by the end of another month he will be able to go back to this type of work.

(*Id.*)

On June 18, 1998, Weishaar returned to Dr. Emerson for a follow-up visit. (R. 201) Dr. Emerson noted the following upon examining Weishaar:

> With him in a sitting position, he had 150 degrees of forward flexion. Abduction actively to approximately 120 degrees. Passive range of motion was about the same. External rotation to neutral position in sitting position. Internal rotation of approximately 50 degrees. Giving way type of weakness to rotator cuff testing. It was impossible to get an assessment of that because of the giving way nature of the strength testing exam. In addition, it was hard to evaluate his right wrist discomfort. He has fairly diffuse palpable tenderness about the plantar and dorsal aspect. I felt he had no atrophy. Neurologic evaluation of that extremity is normal.

(*Id.*) Dr. Emerson determined he could do nothing further for Weishaar. (*Id.*) He stated:

> Regarding his wrist discomfort, I am at an end as to what I feel I can do for evaluation and treatment. I do not know what is causing his discomfort. I do not think he has carpal tunnel syndrome. If he does, it is very mild. The options were discussed with him and his wife. His wife was a little more vocal today in that she related there "must be something

> wrong" with the shoulder and wrist to cause him so much pain. Apparently she feels Gary is in a lot of pain. It is difficult to get that feeling from Gary, but I suspect he does have some discomfort. I related to them that I do not know what is causing his wrist pain. The options regarding that would be to see one of my partners for a second opinion regarding those particular symptoms or to be referred to the University of Iowa or Rochester to see if they can figure out the likely cause of the symptoms.
>
> Regarding the shoulder, I do not think anything else can be done. He may have residual discomfort. Whether he will be able to tolerate his particular type of work I do not know. When I broached that topic, he feels a couple more weeks may be of help. However, I told both him and his wife that I do not think that will make a difference. He seems to think he will not be able to tolerate that particular work because of his pain symptoms and he may be right. It is difficult to tell unless he tries going back to work. However, based upon my assessment, I think he will have quick increase in pain of his right upper extremity and will probably not be able to work because of that. This is my assessment. However, I do not think he will be doing any damage to anything by trying to go back to work. I think we are at an impasse. The options include a second opinion regarding right wrist and shoulder pain, either here with one of my partners or at a tertiary care center. A second option is to evaluate work capacity and trying to help him find a job with restrictions that the work capacity evaluation would identify A third option is going back to work and seeing how he does.

(R. 201-02)

On July 8, 1998, A. Marlow, OTR/L, from the NMHC Work Center in Mason City, Iowa, completed a Functional Capacity Evaluation of Weishaar. (R. 232-37) Marlow's findings were decreased right shoulder active range of motion and strength; decreased bilateral grip strength; decreased lateral pinch, 2-point pinch, and 3-point pinch strength; decreased bilateral coordination; limited ability to work with the right upper extremity at

shoulder or above shoulder level; and limited lifting abilities secondary to right shoulder discomfort. (R. 232)

On August 5, 1998, Weishaar saw T. DeBartolo, M.D., at the Upper Extremity Clinic in Mason City, for the pain in his wrist and hand. (R. 226-27) After taking a history[5] and performing a physical, Dr. DeBartolo administered an injection into Weishaar's wrist of Celestone, Xylocaine and Epinephrine. (R. 227)

On August 7, 1998, Dr. Emerson entered the following note in his office records:

> Mr. Weishaar is seeing Dr. DeBartolo for hand symptoms. From that standpoint, I am not sure if the patient is able to go back to his work yet. I have agreed with the work capacity evaluation and the recommendations they have given [i.e., the July 8, 1998, evaluation]. From my standpoint, he could go back to work with those restrictions.

(R. 199)

On August 19, 1998, Weishaar telephoned Dr. DeBartolo, who then made the following notation in his records:

> Mr. Weishaar is a patient that I saw for the first time on August 5 with right upper extremity pain, a significant rotator cuff injury, and complaints consistent with carpal tunnel. Nerve conduction studies showed very mild carpal tunnel syndrome, but he had significant arm pain.
>
> On August 5 the patient had an injection of cortisone into his right carpal tunnel. The patient called back at the 10-day interval and reported at most the injection was beneficial for a couple of days, but there was really no significant relief or alteration of his discomfort. Based on this information, it is my recommendation that a three-phase bone scan be ordered, looking for evidence of autonomic dysfunction.

(R. 225) A three-phase bone scan of Weishaar's wrists indicated "Mild degenerative changes within the wrist joints," but "No evidence for reflex sympathetic dystrophy."

[5] In taking Weishaar's history, Dr. DeBartolo noted Weishaar was taking Amitriptyline for depression. (R. 326) This is the first indication in the record that Weishaar suffered from depression.

(R. 228) On September 9, 1998, Dr. DeBartolo noted Weishaar had "minimal carpal tunnel [that] does not appear to be a significant factor in his ongoing arm pain." (*Id.*)

On October 15, 1998, Weishaar was seen by William I. Parker, M.D., for depression.[6] (R. 195A) Weishaar told Dr. Parker he was having a lot of stress regarding insurance and unemployment, all relating to his shoulder surgery. (*Id.*) Dr. Parker noted "severe irritability, feelings of anger, feelings of hopelessness/helplessness/worthlessness, very moody and crying for no apparent reasons." (*Id.*) Weishaar had difficulty falling asleep and staying asleep, and his appetite was decreased. (*Id.*) He lacked energy and sex drive. (*Id.*) He also reported one episode of suicidal thoughts. (*Id.*) Dr. Parker's assessment was moderate depression. (*Id.*) He discontinued the Amitriptyline and prescribed Celexa, and Trazodone for sleeplessness. (*Id.*) On October 29, 1998, Weishaar was seen by Alan R. Hjelle, M.D., with the Kossuth Regional Health Center, for a recheck of his depression, and Dr. Hjelle noted he was "improving on medicines." (R. 194)

On December 2, 1998, Weishaar was seen by Mark B. Kirkland, D.O., on referral from his employer's insurance company. (R. 238-40) After performing a complete physical examination and reviewing X-rays, Dr. Kirkland injected Weishaar's right shoulder joint with Xylocaine. (R. 239) The injection appeared to improve Weishaar's shoulder movement, and gave him about 30% pain relief. (*Id.*) Dr. Kirkland concluded Weishaar had received appropriate care for his injured shoulder, and was at maximum medical improvement. (R. 240)

On February 3, 1999, Weishaar was seen by Dr. Hjelle for a recheck of his depression. (R. 193) Dr. Hjelle's assessment was "moderate depression, improved." (*Id.*) He increased the dosage of Celexa. (*Id.*)

On February 17, 1999, Dan L. Rogers, Ph.D., completed a Psychological Assessment Report on Weishaar based on a referral from Disability Determination Services

[6]Dr. Parker's office notes reflect that treatment for depression had been ongoing, but earlier records relating to this treatment are not included in the administrative record.

(DDS). (R. 242-46) Dr. Rogers took a history, conducted a mental status examination, and tested Weishaar's intelligence. (R. 242-44) He found Weishaar to be in the borderline retarded range of measured intellect. (R. 244) His performance on subtests for tasks requiring social comprehension and abstract verbal reasoning were particularly poor. (*Id.*) Dr. Rogers's conclusions were as follows:

> It appears, then, that Gary is experiencing a moderate to severe, generalized decline in intellectual efficiency. This could be consistent with his reports of two head injuries, but it could also reflect a senile process. More specialized neuropsychological evaluation would be necessary to further determine this. He is also significantly depressed, partly in reaction to his situation and, probably, also partly in relation to brain dysfunction.
>
> Nevertheless, he is not able to remember instructions, procedures, and locations very well, and he appeared to have some difficulty understanding such matters. His attention, concentration and pace are diminished and he would have difficulty carrying out such instructions. He is not able to interact appropriately with supervisors, coworkers, and the public because of his temper and judgment problems. His judgment is only fair and he would not be able to consistently respond appropriately to changes in the work place.
>
> He is not able to handle funds.

(*Id.*) His diagnosis was as follows:

| | |
|---|---|
| Axis I: | Organic Brain syndrome<br>Adjustment reaction with depressed mood |
| Axis II: | None obvious |
| Axis V: | GAF: 50[7] |

[7] "The GAF score is a subjective determination that represents "the clinician's judgment of the individual's overall level of functioning." AMERICAN PSYCHIATRIC ASSOC., DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, (4th ed. 1994) at 30. It ranges from 100 (superior functioning) to 1 (persistent danger of severely hurting self or others, persistent inability to maintain minimal personal hygiene, or serious suicidal act with clear expectation of death). *See id.* at 32." *Wesley*

(R. 245)

On March 2, 1999, Weishaar was seen at the Kossuth Regional Health Center by Burt J. Bottjen, M.D., for headaches, which had gotten worse after he had stopped taking Trazodone. (R. 193) Dr. Bottjen's assessment was that Weishaar was suffering from probable migraine headaches, and his depression had improved. (*Id.*) On March 17, 1999, Weishaar saw Dr. Bottjen again for a recheck of his headaches. (R. 192) Dr. Bottjen's assessment was: "1) Migraine headaches with the association of tension-type headaches. 2) Depression, improved." (*Id.*)

On March 22, 1999, Dr. Rogers performed another psychological evaluation of Weishaar, and on March 31, 1999, he prepared a second Psychological Assessment Report. (R. 247-53) Dr. Rogers performed the following additional tests: Minnesota Multiphasic Personality Inventory - 2, California Verbal Learning Test, and Validity Indicator Profile (Nonverbal and Verbal Subtests). (R. 247) In his report, he states Weishaar "was referred by Disability Determination Services for additional psychological evaluation regarding his personality and emotional functioning, verbal learning ability, and his motivation to perform at his best on tests." (*Id.*) By way of history, Dr. Rogers referred to his earlier report, but also noted Weishaar's "reports during the earlier evaluation of injuries that he incurred were not consistent with reports in medical records. For example, he reported to me that he lost consciousness, but that is not reported in his records."[8] (*Id.*) Dr. Rogers reached the following conclusions:

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*v. Commissioner of Social Security*, 205 F.3d 1343 (table), 2000 W.L. 191664 at **3 (W.D. Mich. Feb. 11, 2000). A GAF of 50 "indicates either serious symptoms or 'any serious impairment in social, occupational, or school functioning (*e.g.*, no friends, unable to keep a job).' American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders 32 (4th ed. 1994)." *Lewis v. Paul Revere Life Ins. Co.*, 80 F. Supp. 2d 978, 985 (E.D. Wis. 2000).

[8]Dr. Rogers's statement in this regard is in error. As noted previously, the record indicates Weishaar lost consciousness briefly when he was hit in the neck by a baseball bat on June 25, 1997. *See* R. 219-20.

> Present results cause a reconsideration of the previous test results and mental status. He is experiencing a generalized decline in intellectual efficiency, but this is most likely a result of personality and emotional problems. His new learning ability appears adequate and he appears to be not motivated to respond at his best on nonverbal tasks. He is quite concerned about his health, but it is likely that this serves to obtain secondary gains for him, such as avoidance of his generalized anxiety.
>
> Because of his repression defenses, he finds it difficult to remember instructions, procedures, and locations very well, and he is of low intellect which makes it difficult for him to understand instructions unless he is able to concentrate. His attention, concentration and pace are diminished and he would have difficulty carrying out such instructions. He is not able to interact appropriately with supervisors, coworkers, and the public because of his temper and judgment problems. His judgment is only fair and he would not be able to consistently respond appropriately to changes in the work place.
>
> He is not able to handle funds.
>
> Gary is not a good candidate for psychotherapy or counseling because he would be very defensive. He might, though respond to behavioral management techniques and to help with his marital problems.

(R. 249) Dr. Rogers's diagnosis was as follows:

| | |
|---|---|
| Axis I: | Somatoform Disorder<br>(Anxiety disorder secondary to the Somatoform Disorder) |
| Axis II: | Mixed personality disorder, with Histrionic and Compulsive characteristics |
| Axis V: | GAF: 50 |

(R. 249)

A "Residual Physical Functional Capacity Assessment" was completed by R.S. Sims, M.D., on April 8, 1999. (R. 254-61) According to the assessment, Weishaar could lift and/or carry twenty pounds occasionally and ten pounds frequently; stand and/or

walk at least six hours out of an eight-hour workday; sit, with normal breaks, about six hours in an eight-hour workday; and push and/or pull, including operation of hand and/or foot controls, without limitation. (R. 407) He occasionally could crawl, but frequently could do the following: climb (ramp/stairs), balance, stoop, kneel, and crouch. (R. 256) He could climb ladder/rope/scaffolds "less than occasionally." (*Id.*) Weishaar has no visual or communicative limitations. (R. 257-58) He has no manipulative limitations, except he must avoid repetitive motions with his right wrist. (R. 257) He has no environmental limitations, except he must avoid concentrated exposure to extreme cold, vibrations, and hazards such as machinery and heights. (R. 258)

On April 9, 1999, John C. Garfield, Ph.D., completed a "Mental Residual Functional Capacity Assessment" form on Weishaar. (R. 273-76) According to Dr. Garfield, Weishaar was not limited significantly in the ability to remember locations and work-like procedures, or to understand and remember very short and simple instructions. (R. 273) He was moderately limited in the ability to understand and remember detailed instructions, but was not limited significantly in his ability to carry out very short and simple instructions, perform activities within a schedule, maintain regular attendance, be punctual within customary tolerances, sustain an ordinary routine without special supervision, work in coordination with or proximity to others without being distracted by them, or make simple work-related decisions. (*Id.*) He was moderately limited in his ability to carry out detailed instructions and to maintain attention and concentration for extended periods of time, to complete a normal work day and work week without interruptions from psychologically-based symptoms, and to perform at a consistent pace without an unreasonable number and length of rest periods. (R. 273-74) Weishaar also was moderately limited in his ability to accept instructions and respond appropriately to criticism from supervisors, to get along with coworkers or peers without distracting them or exhibiting behavioral extremes, and to respond appropriately to changes in the work setting, but otherwise was not limited significantly in the areas of social interaction or adaptation. (R. 274)

On April 9, 1999, Dr. Garfield competed a supplement to his Mental Residual Functional Capacity Assessment in which he made the following comments:

> This 47 year old man tests psychometrically in the borderline range of intellectual functioning but indications of poor motivation suggest that these may serve as minimal estimates of his actual intellectual functioning. The claimant is preoccupied with his health and may exaggerate the severity of his symptoms as a reflection of secondary gain motivation, according to examining psychologist Dr. Dan Rogers, who finds a Somatoform Disorder and Personality Disorder NOS, with histrionic and compulsive features. After reviewing the evidence, it is concluded that the claimant may have moderate limitations in attention, concentration, and pace and may experience mild to moderate restrictions in interpersonal functioning as well as in his ability to respond appropriately to changes in the work setting. Nevertheless, it is concluded that the claimant is judged capable of engaging in routine, unskilled, competitive employment, when judged from a purely psychological perspective.

(R. 277)

Also on April 9, 1999, Dr. Garfield completed a "Psychiatric Review Technique" form on Weishaar. (R. 262-72) Dr. Garfield found no evidence that Weishaar has any organic mental disorder; schizophrenic, paranoid, or other psychotic disorder; affective disorder; anxiety related disorder; or substance addiction disorder. (R. 262) Weishaar does suffer from mental retardation, consisting of "significantly subaverage general intellectual functioning with deficits in adaptive behavior," evidenced by borderline to low average intellectual functioning. (R. 266) He also has an unspecified somatoform disorder, and a personality disorder consisting of "inflexible and maladaptive personality traits." (R. 267) Dr. Garfield found Weishaar to be slightly restricted in his activities of daily living and moderately restricted in maintaining social functioning. (R. 269) He often is limited in concentration and persistence or pace, which results in a failure to complete tasks in a

timely manner. (*Id*.) Once or twice in the past, he has experienced episodes of deterioration or decompensation in work or work-like settings. (*Id*.)

As part of the Psychiatric Review Technique form, Dr. Garfield prepared a detailed summary. (R. 271) He stated Weishaar's "learning ability appears adequate and he appears to be not motivated to respond at his best on non verbal tasks." (*Id*.) He concluded that "while [Weishaar's] Borderline Intellectual Functioning, his Somatoform Disorder and Personality Disorder NOS are all considered severe mental impairments, the weight of the evidence indicates that none of these conditions meet [the requirements of the listings]." (R. 272)

On May 11, 1999, David L. Jenson, D.C., wrote an opinion letter to DDS concerning Weishaar's headaches and neck pain. (R. 278) He stated the following:

> In my professional opinion, this patient[']s work limitations will relate mostly to his shoulder. The severe headaches, nausea, and dizziness certainly would limit Gary's ability to work on any specific day. More time is needed to determine the effectiveness of Chiropractic care relating to the headache and neck pain. . . . If these symptoms remain then they too . . . will add to more disability.

(*Id*.)

On June 7, 1999, Janet S. McDonough, Ph.D., completed a Psychiatric Review Technique form on Weishaar. (R. 286-96) Dr. McDonough found no evidence Weishaar has any organic mental disorder; schizophrenic, paranoid, or other psychotic disorder; mental retardation or autism; anxiety related disorder; or substance addiction disorder. (R. 286) According to Dr. McDonough, Weishaar does suffer from an affective disorder, consisting of "disturbance of mood, accompanied by a full or partial manic or depressive syndrome, as evidenced by . . . depression." (R. 289) He also has a somatoform disorder, consisting of "physical symptoms for which there are no demonstrable organic findings or known physiological mechanisms," and a personality disorder, consisting of "inflexible and maladaptive personality traits." (R. 291) Dr. McDonough found Weishaar to be slightly

restricted in his activities of daily living and in maintaining social functioning. (R. 293) He seldom is limited in concentration and persistence or pace which results in a failure to complete tasks in a timely manner, and he never has experienced episodes of deterioration or decompensation in work or work-like settings. (*Id.*)

Weishaar underwent a physical Residual Functional Capacity Assessment by Dr. Dennis A. Weis on June 18, 1999. (R. 297-305) Dr. Weis found Weishaar can occasionally lift and carry 20 pounds; frequently lift and carry 10 pounds; stand, walk and sit about six hours in an eight-hour workday; and push and pull without limitation. (*Id.*) Weishaar has occasional limitations in crawling, and frequent limitations in climbing, balancing, stooping, kneeling, and crouching. (R. 299) Weishaar has no visual, communicative, or environmental limitations, but is limited in the ability to reach in all directions with his right arm. (R. 300-01)

In a supplement to this assessment dated June 18, 1999, Dr. Weis concluded as follows:

> The claimant's allegations are generally consistent with the available medical evidence and by and large are credible. Treating sources and examining sources do not make specific recommendations regarding his residual functional capacity. Other than functional capacity evaluation as noted above. The current treating chiropractor, 5-11-99, discusses some symptoms of headache, but there is no evidence that these headaches are continuous or substantially interfere with his activities of daily living. Treating chiropractor states that he is receiving chiropractic treatments two times per week, but does not assess a specific RFC. All evidence considered, the claimant would be capable of RFC as outlined.

(R. 305)

### *3. Vocational expert's testimony*

VE Jeff Johnson testified at the May 23, 2000, hearing. (R. 76-80) The ALJ asked the VE the following hypothetical question, considering a 49-year-old male with a high school degree after three years in special education:

> Past relevant work is set forth in Exhibit 21E. The ability to lift up to 32 pounds occasionally, 20 pounds frequently. Can sit and stand for up to 2 hours at a time for a total of at least 6 of an 8 hour day. Can walk up to 2 blocks. Only occasional climbing of ramps and stairs. Only occasional crawling. Should not do any overhead lifting with right hand. Claimant would need to be limited to simple routine tasks. Should have a job which would require . . . no contact with the general public and limited contact with fellow workers. Based on this hypothetical would the Claimant be able to do any of his past relevant work?

(R. 77) The VE testified the hypothetical claimant would be able to delivery newspapers, but would not be able to perform any of Weishaar's other past relevant work. However, he stated the hypothetical claimant could perform less than a full range of medium, light, and sedentary unskilled employment. (*Id.*) As examples, the VE listed laundry worker, kitchen helper, and cleaner house keeping. (R. 77-78)

Weishaar's attorney asked if the following additional restrictions would change the VE's answer to the ALJ's question: "the individual could do no balancing[,] no work requiring extension of the right arm to its full extension. No exposure to concentrated, no concentrated exposure to dampness or cold. No exposure, no more than moderate exposure to fumes or scents. No more than a regular case with a low level of stress." (R. 78) The VE responded that these additional restrictions would not change his answer to the ALJ's hypothetical question. (*Id.*) When the attorney added as additional restrictions that the hypothetical individual's pace of work was limited to a low pace, and he would have deficiencies in concentration and ability to stay on task at least once per hour, the VE responded the individual would be precluded from all employment. (R. 78-79)

Weishaar's attorney then asked the following hypothetical question:

> An individual who can occasionally lift 32, frequently 20 pounds. A person who can only do occasional climbing, no balancing. Occasional crawling or kneeling. No work requiring extension of the right arm completely in front of him and no overhead reaching. The inability to remember instructions, procedures and locations on a consistent basis. Periodic difficulties understanding an[d] or remembering instructions, procedures and locations. . . . And an inability to interact appropriately with supervisors and coworkers. Not, judgment which is only fair and an inability to respond appropriately on a consistent basis to changes in the work place. Would such an individual be able to engage n competitive employment?

(R. 79) The VE responded the individual would be able to perform the jobs he listed in response to the ALJ's first hypothetical question. (R. 79-80) Weishaar's attorney then added the following additional limitation: "Periodic outburst of anger or temper such that an individual would leave the work sight [sic] without permission on a monthly basis and not return." (R. 80) The VE responded the individual would have "a very difficult time maintaining a job with that limitation." (*Id.*)

### *4. The ALJ's conclusion*

The ALJ found Weishaar had not engaged in substantial gainful activity since November 30, 1997, the date of his alleged disability. (R. 13) The ALJ concluded Weishaar is "status-post right rotator cuff repair, and has rotator cuff disease, headaches, depression, a somatoform disorder with secondary anxiety, and a personality disorder," and that these impairments presented "severe" limitations under the Social Security Administration's Regulations. (R. 17) The ALJ also concluded, however, that Weishaar's right wrist pain was not a severe impairment. (*Id.*) The ALJ found Weishaar's impairments did not meet or equal the "listings" (R. 19), and Weishaar, because of his medically determinable impairments, is no longer able to perform his past relevant work

(R. 22). However, the ALJ found Weishaar "retains the capacity to make an adjustment to work which exists in significant numbers in the national economy." (R. 24)

In reaching his decision, the ALJ found Weishaar's "statements concerning his functional limitations are generally credible in light of the medical history, but do not indicate the presence of disability or limitations so severe in nature that they precluded work activity." (R. 20) The ALJ pointed out Weishaar's testimony that his pain is disabling "is not supported by his description of his daily activities," which included taking care of his own grooming and hygiene, doing some housekeeping chores, shopping, driving two hours a day, watching television, and visiting two times a week for two hours a day. (R. 21) The ALJ also noted that as of the time of the hearing, Weishaar had no regular medical appointments and was taking no strong pain medication. (*Id.*)

Accordingly, the ALJ found Weishaar was not under a disability as defined by the Social Security Act at any time through the date of the decision. (R. 26)

## *III. DISABILITY DETERMINATIONS, THE BURDEN OF PROOF, AND THE SUBSTANTIAL EVIDENCE STANDARD*

Section 423(d) of the Social Security Act defines a disability as the "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months." 42 U.S.C. § 423(d)(1)(A); 20 C.F.R. § 404.1505. A claimant has a disability when the claimant is "not only unable to do his previous work but cannot, considering . . . his age, education and work experience, engage in any other kind of substantial gainful work which exists in [significant numbers in] the national economy . . . either in the region in which such individual lives or in several regions of the country." 42 U.S.C. § 432(d)(2)(A).

To determine whether a claimant has a disability within the meaning of the Social Security Act, the Commissioner follows a five-step process outlined in the regulations.

20 C.F.R. §§ 404.1520 & 416.920; *see Kelley*, 133 F.3d at 587-88 (citing *Ingram v. Chater*, 107 F.3d 598, 600 (8th Cir. 1997)). First, the Commissioner must determine whether the claimant is currently engaged in substantial gainful activity. Second, he looks to see whether the claimant labors under a severe impairment; *i.e.*, "one that significantly limits the claimant's physical or mental ability to perform basic work activities." *Kelley*, 133 F.3d at 587-88. Third, if the claimant does have such an impairment, then the Commissioner must decide whether this impairment meets or equals one of the presumptively disabling impairments listed in the regulations. If the impairment does qualify as a presumptively disabling one, then the claimant is considered disabled, regardless of age, education, or work experience. Fourth, the Commissioner must examine whether the claimant retains the residual functional capacity to perform past relevant work.

Finally, if the claimant demonstrates the inability to perform past relevant work, then the burden shifts to the Commissioner to prove there are other jobs in the national economy that the claimant can perform, given the claimant's impairments and vocational factors such as age, education and work experience. *Id.*; *Hunt v. Heckler*, 748 F.2d 478, 479-80 (8th Cir. 1984) ("[O]nce the claimant has shown a disability that prevents him from returning to his previous line of work, the burden shifts to the ALJ to show that there is other work in the national economy that he could perform.") (citing *Baugus v. Secretary of Health & Human Serv.*, 717 F.2d 443, 445-46 (8th Cir. 1983); *Nettles v. Schweiker*, 714 F.2d 833, 835-36 (8th Cir. 1983); *O'Leary v. Schweiker*, 710 F.2d 1334, 1337 (8th Cir. 1983)).

Step five requires that the Commissioner bear the burden on two particular matters:

> In our circuit it is well settled law that once a claimant demonstrates that he or he is unable to do past relevant work, the burden of proof shifts to the Commissioner to prove, first that the claimant retains the residual functional capacity to do other kinds of work, and, second that other work exists in substantial numbers in the national economy that the claimant is able to do. *McCoy v. Schweiker*, 683 F.2d 1138, 1146-47

(8th Cir. 1982) (*en banc*); *O'Leary v. Schweiker*, 710 F.2d 1334, 1338 (8th Cir. 1983).

*Nevland v. Apfel*, 204 F.3d 853, 857 (8th Cir. 2000) (emphasis added) *accord Weiler*, 179 F.3d at 1110 (analyzing the fifth-step determination in terms of (1) whether there was sufficient medical evidence to support the ALJ's residual functional capacity determination and (2) whether there was sufficient evidence to support the ALJ's conclusion that there were a significant number of jobs in the economy that the claimant could perform with that residual functional capacity); *Fenton v. Apfel*, 149 F.3d 907, 910 (8th Cir. 1998) (describing "the Secretary's two-fold burden" at step five to be, first, to prove the claimant has the residual functional capacity to do other kinds of work, and second, to demonstrate that jobs are available in the national economy that are realistically suited to the claimant's qualifications and capabilities).

Governing precedent in the Eighth Circuit requires this court to affirm the ALJ's findings if they are supported by substantial evidence in the record as a whole. *Weiler v. Apfel*, 179 F.3d 1107, 1109 (8th Cir. 1999) (citing *Pierce v. Apfel*, 173 F.3d 704, 706 (8th Cir. 1999)); *Kelley v. Callahan*, 133 F.3d 583, 587 (8th Cir. 1998) (citing *Matthews v. Bowen*, 879 F.2d 422, 423-24 (8th Cir. 1989)); 42 U.S.C. § 405(g) ("The findings of the Commissioner of Social Security as to any fact, if supported by substantial evidence, shall be conclusive. . . ."). Under this standard, substantial evidence means something "less than a preponderance" of the evidence, *Kelley*, 133 F.3d at 587, but "more than a mere scintilla," *Richardson v. Perales*, 402 U.S. 389, 401, 91 S. Ct. 1420, 1427, 28 L. Ed. 2d 842 (1971); *accord Ellison v. Sullivan*, 921 F.2d 816, 818 (8th Cir. 1990). Substantial evidence is "relevant evidence which a reasonable mind would accept as adequate to support the [ALJ's] conclusion." *Weiler*, 179 F.3d at 1109 (again citing *Pierce*, 173 F.3d at 706); *Perales*, 402 U.S. at 401, 91 S. Ct. at 1427; *accord Hutton v. Apfel*, 175 F.3d 651, 654 (8th Cir. 1999); *Woolf v. Shalala*, 3 F.3d 1210, 1213 (8th Cir. 1993); *Ellison*, 91 F.2d at 818.

Moreover, substantial evidence "on the record as a whole" requires consideration of the record in its entirety, taking into account "'whatever in the record fairly detracts from'" the weight of the ALJ's decision. *Willcuts v. Apfel*, 143 F.3d 1134, 1136 (8th Cir. 1998) (quoting *Universal Camera Corp. v. N.L.R.B.*, 340 U.S. 474, 488, 71 S. Ct. 456, 464, 95 L. Ed. 456 (1951)); *accord Hutton*, 175 F.3d at 654 (citing *Woolf*, 3 F.3d at 1213). Thus, the review must be "more than an examination of the record for the existence of substantial evidence in support of the Commissioner's decision"; it must "also take into account whatever in the record fairly detracts from the decision." *Kelley*, 133 F.3d at 587 (citing *Cline v. Sullivan*, 939 F.2d 560, 564 (8th Cir. 1991)).

In evaluating the evidence in an appeal of a denial of benefits, the court must apply a balancing test to assess any contradictory evidence. *Sobania v. Secretary of Health & Human Serv.*, 879 F.2d 441, 444 (8th Cir. 1989) (citing *Gavin v. Heckler*, 811 F.2d 1195, 1199 (8th Cir. 1987)). The court, however, does "not reweigh the evidence or review the factual record *de novo.*" *Roe v. Chater*, 92 F.3d 672, 675 (8th Cir. 1996) (quoting *Naber v. Shalala*, 22 F.3d 186, 188 (8th Cir. 1994)). Instead, if, after reviewing the evidence, the court finds it "possible to draw two inconsistent positions from the evidence and one of those positions represents the agency's findings, [the court] must affirm the [Commissioner's] decision." *Robinson v. Sullivan*, 956 F.2d 836, 838 (8th Cir. 1992) (citing *Cruse v. Bowen*, 867 F.2d 1183, 1184 (8th Cir. 1989)); *see Hall v. Chater*, 109 F.3d 1255, 1258 (8th Cir. 1997) (citing *Roe v. Chater*, 92 F.3d 672, 675 (8th Cir. 1996)). This is true even in cases where the court "might have weighed the evidence differently," *Culbertson v. Shalala*, 30 F.3d 934, 939 (8th Cir. 1994) (citing *Browning v. Sullivan*, 958 F.2d 817, 822 (8th Cir. 1992)), because the court may not reverse "the Commissioner's decision merely because of the existence of substantial evidence supporting a different outcome." *Spradling v. Chater*, 126 F.3d 1072, 1074 (8th Cir. 1997).

On the issue of an ALJ's determination that a claimant's subjective complaints lack credibility, the Sixth and Seventh Circuits have held an ALJ's credibility determinations are

entitled to considerable weight. *See, e.g., Young v. Secretary of H.H.S.,* 957 F.2d 386, 392 (7th Cir. 1992) (citing *Cheshier v. Bowen,* 831 F.2d 687, 690 (7th Cir. 1987)); *Gooch v. Secretary of H.H.S.,* 833 F.2d 589, 592 (6th Cir. 1987), *cert. denied,* 484 U.S. 1075, 108 S. Ct. 1050, 98 L. Ed. 2d. 1012 (1988); *Hardaway v. Secretary of H.H.S.,* 823 F.2d 922, 928 (6th Cir. 1987). Nonetheless, in the Eighth Circuit, an ALJ may not discredit a claimant's subjective allegations of pain, discomfort or other disabling limitations simply because there is a lack of objective evidence; instead, the ALJ may only discredit subjective complaints if they are inconsistent with the record as a whole. *See Hinchey v. Shalala,* 29 F.3d 428, 432 (8th Cir. 1994); *see also Bishop v. Sullivan,* 900 F.2d 1259, 1262 (8th Cir. 1990) (citing *Polaski v. Heckler,* 739 F.2d 1320, 1322 (8th Cir. 1984)). Under *Polaski:*

> The adjudicator must give full consideration to all of the evidence presented relating to subjective complaints, including the claimant's prior work record, and observations by third parties and treating and examining physicians relating to such matters as:
>
> 1) the claimant's daily activities;
> 2) the duration, frequency and intensity of the pain;
> 3) precipitating and aggravating factors;
> 4) dosage, effectiveness and side effects of medication;
> 5) functional restrictions.

*Polaski,* 739 F.2d at 1322.

## *IV. ANALYSIS*

### *A. Improper Reliance by the ALJ on Medical/Vocational Guidelines*

As noted previously, Weishaar argues the ALJ improperly relied on the medical-vocational guidelines in denying his claim of disability. In particular, Weishaar argues that if an individual cannot perform the full range of light work, reliance upon the "grid"[9] for

[9]The "Grids" are "fact-based generalizations about the availability of jobs for people of varying ages, educational backgrounds, and previous work experience, with differing degrees of exertional

light work is not permitted (citing *Fenton v. Apfel*, 149 F. 3d 907, 911 (8th Cir. 1998). He argues the ALJ relied on the medical-vocational guidelines even though Weishaar was unable to perform the full rage of light duties because of his limited use of his right upper extremity together with other significant nonexertional impairments. He asks that the case be remanded to the ALJ to obtain vocational expert testimony.

The basic problem with this argument is the ALJ did not rely on the grid[10] in finding Weishaar not to be disabled, and did, in fact, obtain testimony from a VE. The ALJ relied on the VE's testimony in finding that Weishaar could

> make a vocational adjustment to light and sedentary work such as that of a laundry worker, with approximately 130,000 such jobs in the national economy and 1,000 of those in Iowa; a kitchen helper, with approximately 300,000 such jobs in the national economy and 1,300 of those in Iowa; and a cleaner/house, with approximately 350,000 such jobs in the national economy and 3,200 of those in Iowa.

(R. 23) Weishaar's argument simply makes no sense, and is accordingly rejected.

### *B. Incorrect Hypothetical Question by ALJ*

Weishaar also argues the ALJ failed to ask a proper hypothetical question of the VE. He contends "the hypothetical question posed to the vocational expert by the ALJ did not include restrictions of right upper extremity reaching and handling." (Doc. No. 6, p. 10) He also contends the VE failed "to consider Weishaar's borderline intellectual functioning as a vocational factor." (*Id.*, at pp.10-11)

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impairment." *Pearsall v. Massanari*, 274 F.3d 1211, 1219 (8th Cir. 2001) (citing *Gray v. Apfel*, 192 F.3d 799, 802 (8th Cir.1999)).

[10]Contrary to Weishaar's argument, the ALJ found he could *not* apply the grid because "the claimant has nonexertional limitations which narrow the range of work he is capable of performing." (R. 23)

The Eighth Circuit has held an ALJ's hypothetical question must fully describe the claimant's abilities and impairments as evidenced in the record. *See Chamberlain v. Shalala*, 47 F.3d 1489, 1495 (8th Cir. 1995) (citing *Shelltrack v. Sullivan*, 938 F.2d 894, 898 (8th Cir. 1991)). A hypothetical question is "sufficient if it sets forth the impairments which are accepted as true by the ALJ." *Johnson v. Chater*, 108 F.3d 178, 180 (8th Cir. 1997); *House v. Shalala*, 34 F.3d 691, 694 (8th Cir. 1994). Only the impairments substantially supported by the record as a whole must be included in the ALJ's hypothetical. *Cruze v. Chater*, 85 F.3d 1320, 1323 (8th Cir. 1996) (citing *Stout v. Shalala*, 988 F.2d 853, 855 (8th Cir. 1993)). If a hypothetical question does not encompass all relevant impairments, the vocational expert's testimony does not constitute substantial evidence to support the ALJ's finding of no disability. *Cruze*, 85 F.3d at 1323 (citing *Hinchey v. Shalala*, 29 F.3d 428, 432 (8th Cir. 1994)). The ALJ may produce evidence of suitable jobs by eliciting testimony from a VE "concerning availability of jobs which a person with the claimant's particular residual functional capacity can perform." *Cox v. Apfel*, 160 F.3d 1203, 1207 (8th Cir. 1998). A "proper hypothetical question presents to the vocational expert a set of limitations that mirror those of the claimant." *Hutton v. Apfel*, 175 F.3d 651, 656 (9th Cir. 1999).

In *Wiekamp v. Apfel*, 116 F. Supp. 2d 1056 (N.D. Iowa 2000), Chief Judge Mark Bennett explained further the requirements for a proper hypothetical question posed to a VE:

> "Testimony from a vocational expert is substantial evidence only when the testimony is based on a correctly phrased hypothetical question that captures the concrete consequences of a claimant's deficiencies." *Taylor v. Chater*, 118 F.3d 1274, 1278 (8th Cir. 1997). Although "questions posed to vocational experts should precisely set out the claimant's particular physical and mental impairments, . . . a proper hypothetical question is sufficient if it sets forth the impairments which are accepted as true by

> > the ALJ." *House v. Shalala*, 34 F.3d 691, 694 (8th Cir. 1994) (internal citations, quotation marks, and alterations omitted).
>
> *Roberts v. Apfel*, 222 F.3d 466, 471 (8th Cir. 2000). "The hypothetical need not use specific diagnostic terms . . . where other descriptive terms adequately describe the claimant's impairments." *Warburton* [*v. Apfel*], 188 F.3d [1047,] 1050 [(8th Cir. 1999)]. An ALJ is not required to include in a hypothetical question to a vocational expert any impairments that are not supported by the record. *Prosch*, 201 F.3d at 1015. However, where an ALJ improperly rejects the opinion of a treating physician or subjective complaints of pain by the claimant, the vocational expert's testimony that jobs exist for the claimant does not constitute substantial evidence on the record as a whole where the vocational expert's testimony does not reflect the improperly rejected evidence. *See Singh*, 222 F.3d at 453 ("In view of our findings that the ALJ improperly rejected both the opinion of Singh's treating physician and Singh's subjective complaints of pain, we find that the hypothetical question posed to the vocational expert did not adequately reflect Singh's impairments. Accordingly, the testimony of the vocational expert that jobs exist for Singh cannot constitute substantial evidence on the record as a whole.").

*Wiekamp*, 116 F. Supp. 2d at 1073-74.

In the present case, Weishaar argues the hypothetical questions posed to the VE improperly failed to include (1) "restrictions of [Weishaar's] right upper extremity reaching and handling," (2) his borderline intellectual functioning as a vocational factor, and (3) his other nonexertional impairments ("headaches, somatoform disorder, mixed personality disorder, and depression"). (Doc. No. 6, pp. 10-11)

The court has carefully reviewed the hypothetical questions posed to the VE. The ALJ specifically included the restriction that the hypothetical claimant could not do any overhead lifting with his right hand, and should do no work requiring extension of the right arm to its full extension. (R. 77-78) However, nothing in the hypothetical questions makes

reference to Weishaar's borderline intellectual functioning or to his other nonexertional impairments. In particular, no reference is made to his headaches, depression, somatoform disorder, or personality disorder. The ALJ specifically found Weishaar suffered from all of these limitations. (R. 17) Failure to include them in the hypothetical question was error.

## *V. CONCLUSION*

For the reasons set forth above, **IT IS RECOMMENDED**, unless any party files objections[11] to the Report and Recommendation in accordance with 28 U.S.C. § 636 (b)(1)(C) and Fed. R. Civ. P. 72(b), within ten (10) days of the service of a copy of this Report and Recommendation, that judgment be entered in favor of Weishaar[12] and against the Commissioner, and that this case be **reversed and remanded** to the Commissioner for pursuant to sentence four of 42 U.S.C. § 405(g), for further proceedings. The Commissioner should be instructed to obtain additional testimony from the VE in connection with a proper hypothetical question that considers all of Weishaar's limitations.

**IT IS SO ORDERED.**

**DATED** this 23rd day of February, 2002.

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[11]Objections must specify the parts of the report and recommendation to which objections are made. Objections must specify the parts of the record, including exhibits and transcript lines, which form the basis for such objections. *See* Fed. R. Civ. P. 72. Failure to file timely objections may result in waiver of the right to appeal questions of fact. *See Thomas v. Arn*, 474 U.S. 140, 155, 106 S. Ct. 466, 475, 88 L. Ed. 2d 435 (1985); *Thompson v. Nix*, 897 F.2d 356 (8th Cir. 1990).

[12]If final judgment is entered for the plaintiff, the plaintiff's counsel must comply with the requirements of Local Rule 54.2(b) in connection with any application for attorney fees.

PAUL A. ZOSS
MAGISTRATE JUDGE
UNITED STATES DISTRICT COURT